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Official Report of Debates (Hansard)

Thursday 23 November 2006

Journal des débats (Hansard)

Jeudi 23 novembre 2006

Standing committee on the Legislative Assembly

Mandatory Blood
Testing Act, 2006

Comité permanent de l'Assemblée législative

Loi de 2006 sur le dépistage
obligatoire par test sanguin

Chair: Bob Delaney
Clerk: Tonia Grannum

Président : Bob Delaney
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Thursday 23 November 2006

Jeudi 23 novembre 2006

The committee met at 1530 in committee room 1.

MANDATORY BLOOD TESTING ACT, 2006

LOI DE 2006 SUR LE DÉPISTAGE OBLIGATOIRE PAR TEST SANGUIN

Consideration of Bill 28, Bill 28, An Act to require the taking and analysing of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons and to make consequential amendments to the Health Care Consent Act, 1996 and the Health Protection and Promotion Act / Projet de loi 28, Loi exigeant le prélèvement et l'analyse d'échantillons de sang afin de protéger les victimes d'actes criminels, le personnel des services d'urgence, les bons samaritains et d'autres personnes et apportant des modifications corrélatives à la Loi de 1996 sur le consentement aux soins de santé et à la Loi sur la protection et la promotion de la santé.

The Chair (Mr. Bob Delaney): Good afternoon, everybody. We are here to consider Bill 28, An Act to require the taking and analyzing of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons and to make consequential amendments to the Health Care Consent Act, 1996, and the Health Protection and Promotion Act.

SUBCOMMITTEE REPORT

The Chair: Our first order of business will be a report from the subcommittee. Ms. Mossop.

Ms. Jennifer F. Mossop (Stoney Creek): Your subcommittee met on Tuesday, November 7, 2006, to consider the method of proceeding on Bill 28, An Act to require the taking and analysing of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons and to make consequential amendments to the Health Care Consent Act, 1996, and the Health Protection and Promotion Act, and recommends the following:

(1) That the committee meet for public hearings on Thursday, November 23, 2006, at Queen's Park.

(2) That the clerk of the committee post information regarding public hearings on Bill 28 on the Ontario parliamentary channel and the committee's website.

(3) That staff of the Ministry of Community Safety and Correctional Services be invited to provide the committee with a 30-minute briefing and question period prior to the start of public hearings on Thursday, November 23, 2006.

(4) That interested parties who wish to be considered to make an oral presentation on Bill 28 contact the clerk of the committee by 5 p.m. on Monday, November 20, 2006.

(5) That if all witnesses cannot be accommodated, the clerk provide the subcommittee members with the list of witnesses who have requested to appear by 5:30 p.m. on Monday, November 20, 2006, and that the caucuses provide the clerk with a prioritized list of witnesses to be scheduled by 12 p.m. on Tuesday, November 21, 2006.

(6) That the deadline for written submissions on Bill 28 be 5 p.m. on Tuesday, November 28, 2006.

(7) That all witnesses be offered a maximum of 20 minutes for their presentation, with discretion given to the Chair and clerk of the committee to reduce witness presentation time, should the need warrant.

(8) That for administrative purposes, proposed amendments should be filed with the clerk of the committee by 4 p.m. on Wednesday, November 29, 2006.

(9) That the committee meet tentatively on Thursday, November 30, 2006, for clause-by-clause consideration of Bill 28 (subject to change).

(10) That the research officer provide the committee with background information on the current practice prior to the start of public hearings, and that the research officer provide the committee with a summary of public hearings prior to clause-by-clause consideration.

(11) That the clerk of the committee, in consultation with the Chair, be authorized, prior to the adoption of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair: Thank you very much. Adoption of the report of the subcommittee? Carried.

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

The Chair: Our first order of business will be a presentation by the Ministry of Community Safety and Correctional Services. You'll have up to 15 minutes, if you need the time, to present to us. Please begin by introducing yourself for the purposes of Hansard. After

you're done, each party in rotation will have up to five minutes for questions. Proceed when you're ready.

Mr. Stephen Waldie: Good afternoon. I'm Steve Waldie, director of policy with the Ministry of Community Safety and Correctional Services. With me today is Marnie Corbold, who is legal counsel for the ministry.

As mentioned, we are here to give you an overview of Bill 28, the Mandatory Blood Testing Act. To do that, I'm going to walk you through the slide deck that I think you have in front of you.

Starting on page 3, I'll just give you some context about how we got here. The legislation on mandatory blood testing was originally introduced via a private member's bill and took effect in September 2003.

The current provisions are contained in section 22.1 of the Health Protection and Promotion Act. The current legislation enables persons who have come into contact with the bodily substances of another person while providing emergency health care services, emergency first aid or as a result of being a victim of crime to make an application to a medical officer of health to determine the HIV/AIDS, hepatitis B or hepatitis C status of the source of exposure. It further provides that if a person does not voluntarily provide a blood sample, a medical officer of health can order the required sampling and testing.

Just a bit more for your reference: Between September 2003 and June 2005, 76 applications were made. Of these, 39 were resolved voluntarily, 26 were dismissed, 10 were refused and one order was issued.

On to page 5: The primary objectives of Bill 28 are to streamline the process and to ensure that applications are dealt with in an efficient, effective and timely manner for all concerned. It also intends to strike a balance among the interests of the applicant, the respondent, workers and those administering the process. It also specifically responds to concerns expressed by the police and other public safety workers that the procedures and process are too lengthy under the current legislation. And it responds to medical officers of health who have concerns with their role as adjudicators.

Key changes: One of the key changes is with respect to timing. The timeline for a medical officer of health to attain the voluntary compliance of the respondent has been shortened from seven days to two days. A hearing conducted by the Consent and Capacity Board into an application must be held and concluded within seven days after the application has been referred to the board. And the board's decision must be given within one day after concluding a hearing. So in total time, the maximum time from the receipt of an application to a decision would now be 19 days. Under the current process, it can take up to 70 days.

The other key change in the bill is that Bill 28 transfers the power to make an order from a medical officer of health to the Consent and Capacity Board. Medical officers of health will maintain responsibility for screening applications, seeking voluntary blood samples and supervising the execution of orders.

I'm now going to walk you through the process that the new bill proposes. For those who are more graphically inclined, there is a flowchart of the process on page 14, or you can follow the words on the next few slides.

The front end of the bill essentially remains the same. Those who have come in contact with the bodily substance of another person, in circumstances set out in the act or as prescribed by regulation, which are the same as the current act—as a result of being a victim of crime, or while providing emergency health care services, emergency first aid or other prescribed classes or prescribed activities as set out in regulations—may apply to a medical officer of health to have the blood of the other person analyzed.

Page 9: The medical officer of health is responsible for seeking voluntary compliance from the respondent within two days. If voluntary compliance is not obtained or the respondent cannot be located, the medical officer of health must refer the application to the Consent and Capacity Board for consideration. The chair of the board is permitted to appoint a quorum of one to consider the application if the chair believes that the member has expertise with respect to blood-borne pathogens and meets all other qualifications required by the chair.

1540

As I previously stated, the board must commence and conclude a hearing within seven days, and the board must make its decision within one day of the hearing ending. If the board makes an order directing that the respondent provide a blood sample, notice shall be given to the respondent, the applicant, counsel for both parties and the medical officer of health. A decision of the board is final; there is no right of appeal, although a request for judicial review of the board's decision is still available.

If the respondent does not comply with an order, the applicant may apply to a judge of the Superior Court for an order requiring that the respondent comply with the order. The bill also provides that anyone who fails to obey an order of the board, or contravenes or fails to comply with any requirement under the act, is guilty of an offence and liable for not more than $5,000 a day. This is consistent with offence provisions set out in the Health Protection and Promotion Act.

Finally, the bill provides the Minister of Community Safety and Correctional Services with broad regulation-making authority, including but not limited to prescribing diseases that are listed as communicable; prescribing classes of persons who can make an application; prescribing circumstances and activities; defining "victim of crime"; governing an application to a medical officer of health and actions taken by a medical officer of health; and prescribing rules governing an application as deemed to be received by a medical officer of health or the board. I thank you.

Mr. Peter Kormos (Niagara Centre): Chair, just a question: What time is it?

The Chair: I have 3:40.

Mr. Kormos: Okay. May I suggest that we seek unanimous consent that the balance of this half-hour, the 20 minutes, be divided equally three ways—because we don't have the first presenter until 4—in terms of questions of these folks?

The Chair: If the first presenter shows up—do you have any questions beyond your allocated five minutes?

Mr. Kormos: He's scheduled for 4 o'clock.

Mr. Ted McMeekin (Ancaster–Dundas–Flamborough–Aldershot): The first presenter is here.

The Chair: The first presenter is here?

Mr. Kormos: He's scheduled for 4, but—okay. Let's get going.

The Chair: Okay. Mr. Dunlop? Mr. Miller?

Mr. Garfield Dunlop (Simcoe North): Just on behalf of the official opposition, I really have no comments. I'm hoping that this will do better than the private member's bill, which of course you knew I was a part of. I know my colleague Norm Miller has a few comments—

Interruption.

Mr. Dunlop: I think it's my cellphone. Sorry. I didn't realize it was my phone.

Mr. Kormos: Do you keep it on vibrate as a rule?

Mr. Dunlop: I keep it on silent. I didn't realize it was going to cause the communications system here to go bad.

Anyhow, all I was saying was that I understand, in talking to any of the stakeholders I've dealt with in the past, that they're fairly happy with the changes. I guess the only question I would have before I—I know my colleague Norm Miller has a couple of questions. Do you see any roadblocks that could be thrown in front of this bill now that would obstruct the bill from being put through in its normal form?

Mr. Waldie: Any time you're talking about taking blood sampling from a person, it is a very invasive procedure and some people do not like that. So you may hear some concerns about that actual process. We have talked to the stakeholders involved in drafting the legislation, and it tries to present a balance to that situation.

Mr. Norm Miller (Parry Sound–Muskoka): Thank you for your presentation and thank you to Garfield Dunlop, the member from Simcoe North, for bringing the original private member's bill forward upon which you are now, I assume, improving and speeding up, by the sounds of things, with Bill 28.

I guess a couple of questions just to do with process: First of all, for the individual worker, whether they be a paramedic or a police officer, who needs to make access to this bill—run me through the process that they go through. Is it just them writing a letter? What is involved? Is it fairly simple, I guess is what I'm getting at, for the worker who wants to make access and get the results in making use of this bill?

Mr. Waldie: The worker will have to fill out an application form that will—

Mr. Norm Miller: Will there be a standard application form?

Mr. Waldie: There will be a standard application, yes.

Mr. Norm Miller: They will be able to access that online, I assume?

Mr. Waldie: They will be. One of the key components I think the ministry sees with the bill is education, to make sure that people understand the bill, what the bill can do and how to use the bill.

Mr. Norm Miller: What happens when you go through the process and the respondent doesn't co-operate? So then the person affected has to apply to a Superior Court judge?

Mr. Waldie: Right.

Mr. Norm Miller: I am not a lawyer like Peter here, so how expensive a process is that? I assume they would have to hire a lawyer to make that application. How long would that take?

Mr. Waldie: They would certainly have the choice to retain counsel. It would be a matter of the court, how quickly it could get before the court and how quickly it could be dealt with.

Mr. Norm Miller: Courts are not known for being exactly speedy, so that could be a real stumbling block if you got an unco-operative respondent that you were dealing with.

Mr. Waldie: It could be a challenge to the applicant.

Mr. Norm Miller: Okay. In your presentation you said that between 2003 and June 2005, only one order was issued.

Mr. Waldie: Correct.

Mr. Norm Miller: So is that being corrected now in Bill 28 so that more orders will be issued? I can't imagine that of 76 applications only one would be successful.

Mr. Waldie: One of the challenges we had in reviewing how the current legislation works was real access to information about those decisions that were being made. We don't really have good information about how those decisions were made. I think just the length of the processes alone may have been seen as a stumbling block to actually even applying for the sample to be taken. To be honest, we don't really know what to expect.

Mr. Norm Miller: Thank you very much. It looks like it's going to be speeding up the process. I guess the point of my questions is that the simpler it can be, the less expensive for those who need to make use of it, and the faster they can make use of it, the better.

The Chair: Mr. Kormos.

Mr. Kormos: We support the proposition, just as we did the original legislation. I'm fascinated, though, by the statistics to date. Thirty-nine were resolved voluntarily. That meant that people were notified of their obligation to provide a sample of blood and they said, "By all means. Where do I do it? Where do I go?" and what have you.

My suspicion is that the person least likely to voluntarily participate is the perpetrator of a crime, where the person being impacted is the victim of the crime. Is that just an assumption or has that been reflected in the data?

Mr. Waldie: I believe you're correct. The majority of applications have come from victims, or a significant number have come from victims of crime. How that process played out, we don't know.

Mr. Kormos: What I'm interested in, for instance, I can't, for the life of me—if again, that radial arm saw takes off—I wouldn't want to have it take off my left hand. As a left winger I'd rather my right hand go, but if it were to take off my right hand and paramedics are coming, I'm going to be grateful enough that they can

take as many samples of blood as possible, right? But you don't have data that identifies who's voluntarily participating and who's not?

Mr. Waldie: We don't.

Mr. Kormos: Is that available anywhere? Let's see if we can get that, okay?

The other thing is that 26 were dismissed as "application incomplete." That's peculiar. What happened? Were these people who made an error in the application and they got dismissed because of an error in the application?

Mr. Waldie: You're not going to like my answer again, but we don't have the answers why. The applications were incomplete, and it's possible they didn't know the name of the person they came into contact with, and the information provided made it impossible to take action to contact the respondent. But the specific examples of every case we don't know.

1550

Mr. Kormos: You understand why that's of concern, because if a mere technicality and omission of checking a box, what have you, causes an application to be dismissed, that puts innocent people at risk on the basis of mere procedural things. Maybe, Ms. Luski, you could work with these folks, and we could try to find that out.

Ten were refused. Only one order was issued. The refusals—that means the medical officer of health said no. Can you canvass some of the rationale? What are the considerations that the MOH makes when he or she refuses?

Ms. Marnie Corbold: The actual considerations that they're looking at are similar to what we have in section 5, so they're looking at reasonable and probable grounds that they came into contact with a bodily substance of the other person, that they may have become infected, that testing the respondent's blood won't jeopardize their health. So it's similar considerations, and I guess the ultimate one is that the analysis is necessary to eliminate the risk to the health or safety of the applicant. Those are the considerations the medical officers of health are looking at, similar to section 5.

Mr. Kormos: But in real-world terms, what does that mean? Does it mean if I say, "Oh, some blood got on my forearm," and I didn't have any open wounds, then the medical officer of health can say, "Oh, come on. You can't contract anything that way"? Do I have to have it sprayed in my face before—those are the two extremes, right? Can you give us a real-life example of where somebody had contact with blood and where the MOH would say no?

Ms. Corbold: I don't think we know the details of any of the specific cases, what the factual circumstances were, so I can't really comment on that.

Mr. Kormos: And why do medical officers of health, because you're involving the CCB—it's a Toronto-based operation?

Mr. Waldie: No, it's not.

Mr. Kormos: Where is it based?

Mr. Waldie: It's available province-wide.

Mr. Kormos: I know, but where's it based?

Ms. Corbold: I think it is based in Toronto.

Mr. Kormos: Toronto-based. They've got members all over the province, right? So that's what you're suggesting: These members will be accessed to conduct the hearings—

The Chair: Thank you very much. Mr. Balkissoon.

Mr. Bas Balkissoon (Scarborough–Rouge River): Thank you very much for your presentation and for all the work you've done on this particular bill. We appreciate it.

Mr. Kormos: What about all the policy people in the back, in the corner? They've been working hard on this for months.

Mr. Balkissoon: All of them are included, the whole ministry.

POLICE ASSOCIATION OF ONTARIO

The Chair: Our first deputation this afternoon is the Police Association of Ontario and a gentleman who needs no introduction to anybody here unless they've just been elected: Bruce Miller. Welcome. Although you know the drill, for the benefit of your associate, you'll have up to 20 minutes to make your submission, and if you leave any time remaining, it will be divided among the parties for questions. Please begin by stating your names for Hansard, and proceed.

Mr. Bruce Miller: Thank you. My name is Bruce Miller, and I'm the chief administrative officer for the Police Association of Ontario. I was also a front-line police officer for over 20 years prior to taking on my current responsibilities. With me today is Natalie Hiltz of the Peel Regional Police Service.

The Police Association of Ontario represents over 30,000 police and civilian members from every municipal police association and the Ontario Provincial Police Association. We appreciate the opportunity to provide input into this important process.

We are here today in support of Bill 28 and to stress the need for effective mandatory blood testing for individuals who may have infected an emergency worker, a victim of crime or a good Samaritan.

We'd like to acknowledge the hard work that was done on this issue by Simcoe North MPP Garfield Dunlop, who had his groundbreaking private member's bill proclaimed in 2003. The legislation was the first of its kind in Canada. Mr. Dunlop was a real champion for us on this issue, and any problems that arose with the legislation couldn't be foreseen at that time.

Thank you very much, Garfield. We really appreciate everything you did for us.

Since the introduction of Mr. Dunlop's legislation, many stakeholders have come together to share their experiences, which, in turn, has helped to shape the legislation introduced by the McGuinty government. The Minister of Community Safety and Correctional Services, Monte Kwinter, introduced legislation last November which we believe achieves the right balance of protecting emergency responders, victims of crime and good Samaritans and those who place them at risk.

A number of years ago, I performed CPR on an individual who unfortunately did not survive. The coroner was concerned that the individual may have had spinal meningitis and ordered an immediate autopsy that confirmed his suspicions. I was called at home late at night and told to attend the local emergency ward to begin treatment, which I did. If the individual had survived, I may not have been privy to the same information.

I will now ask Natalie Hiltz to tell you her story.

Ms. Natalie Hiltz: I'm Constable Natalie Hiltz, with the Peel Regional Police Service. I want to tell you about an incident that happened to me when I was 26 years old and in my rookie year. The day was Saturday, June 14, 1997. It was 8 in the morning and was the start of what I thought would be a routine day.

I was sent on a domestic disturbance call with another officer. We arrived and separated the two people who were involved. I was dealing with a female, who pushed me and ran. I chased her and she bit me on my left hand while I was effecting an arrest. She broke my skin, and it was bleeding.

As it turned out, she had bitten someone else before I arrived. I was told that she was a well-known prostitute, she was a heavy intravenous drug user and crack addict. Most importantly, she was a street person who was believed to be HIV-positive. She looked sick, her gums were bleeding, and I immediately knew that I was in trouble.

I went to Credit Valley Hospital, where I was told by a doctor that my risk of contraction was high. He advised me to take the drug cocktail and told me that it was 8O% effective. The person who bit me refused to be tested. At the time, I believed that my life was in serious danger. The hospital needed me to pay for the medication before they would administer treatment. I called my fiancé, who brought down a credit card so that I would be able to pay for the drugs that could save my life.

The side effects were severe. I had chronic fatigue and nausea. The emotional effects were far worse. The doctor warned me that the drugs could cause cancer or birth defects, and I worried about the effects on my loved ones. I was able to get through the ordeal, thanks to the support from my fiancé, my family, my friends, my co-workers, my police association and my police service.

My story had a happy ending. I have been given a clean bill of health. My fiancé is now my husband, and we have two wonderful children.

I am here today because I went through a terrible ordeal, and I want to do whatever I can to lessen the burden for those who will surely have to go through what I went through. I can't give you figures on the risk or number of exposures; I can only tell you of my personal experience. It turned out that the person who bit me was in fact HIV-positive. I would have had to take the medication in any event.

I can't tell you what I would have done if, after taking the medication, the person had been tested and had been given a clean bill of health. What I can tell you is this: I can tell you that I would have based my decision on consultations with my physician. I can tell you that I would have been able to make an informed decision with all the possible information. I can tell you that it would have taken away a lot of the uncertainty, the fear of the unknown. I can also tell you that the emotional toll is extremely high and that it is human nature to think the worst.

We need to be able to make informed decisions based on all the possible information. It's my sincere hope that the legislation can move forward as quickly as possible.

Mr. Bruce Miller: Thanks, Natalie. I don't know how much more I can add after your presentation. I think your story underscores the need to move this legislation forward.

The police officer who is bitten and then told by the offender that he or she has AIDS should be able to make an informed decision on treatment. The sexual assault victim has the same common-sense right. A good Samaritan who performs mouth-to-mouth resuscitation on an individual has the right to know whether or not he or she has put his or her own health at risk.

1600

We have countless examples of deliberate attacks on police personnel by people with, or claiming to have, HIV and other diseases. Rubber gloves and universal precautions only reduce the risk. We have had members spat upon, deliberately bitten and exposed to free-flowing blood and other bodily fluids by an attacker or individual. I know because it happened to me numerous times.

Lax federal laws and inadequate legislation and sentencing provisions only serve to increase the incidents. We need to protect victims and those who protect us. We respect the right to privacy, but at some point that right must be balanced with the need to protect society.

Mandatory blood testing would allow individuals to make properly informed decisions about post-exposure treatment. The so-called drug cocktail that is administered to post-exposure victims brings its own well-documented medical risks.

We are also informed that physicians will treat a person more aggressively if they know that the individual who may have infected the person tested positive. This legislation can help to save lives.

We've reviewed the legislation in detail and are not proposing any amendments. In support, we would like to thank Garfield Dunlop and Minister Kwinter for all their efforts, and call upon the members of all three parties to move this legislation forward as quickly as possible.

We'd be pleased to answer any questions you may have.

The Chair: Thank you very much. We should have three or four minutes for each party, beginning with Mr. Dunlop.

Mr. Dunlop: I just want to say thanks for coming again. I talked to you last week at police lobby day, and you mentioned at that point that you had no amendments. I want to thank you for being here.

Natalie, I want to thank you again. You were there in 2001 or shortly after—that was before you had the two babies, I think. I just want to congratulate you for keeping up this challenge that you've faced in the past. When-

ever we hear the story, it brings this whole issue back to heart. As long as you can keep telling that story, I think you'll be helping police officers and good Samaritans across the province.

I have no other comments.

The Chair: Mr. Miller.

Mr. Norm Miller: Thank you for your presentation. Have you any suggestions for the worst-case scenario, where the respondent doesn't co-operate so you then go through the process, and the last recourse, I guess, is for the victim, whether it be a police officer or a paramedic, to go before the Superior Court? Have you any suggestions that you would recommend for that process with respect to a police officer?

Mr. Bruce Miller: As I said, we've looked at the legislation, and there is a balance dealing with privacy issues—our solicitors have looked at it as well. I suppose, in our hearts, police personnel like to see the timelines tightened as much as possible, but realistically, that opens up legislation to charter challenges. Our lawyers have told us that they believe the right balance has been achieved and that any further tightening of timelines would result in our losing on a charter challenge. The timelines have been shorted from about 65 or 70 days to about 15 or 16 now, so it's far superior.

We did have some problems—certainly medical officers of health expressed a lot of reservations about acting as judiciary or making decisions on this matter. So I think the new process with the Consent and Capacity Board, who are used to making these types of decisions, will work far better.

The Chair: Mr. Kormos.

Mr. Kormos: Thank you, folks. Look, everybody supports the legislation. I suppose it's far more important that we hear if there are any caveats; in other words, if there are any warnings we should be getting about the legislation in terms of anything being ineffective or not being as effective as it should be. Yes, we should be moving with and looking forward to making sure—look, nobody proposed amendments the first time around. That's fair enough—it's not a criticism of anybody—but experience has demonstrated the need for them.

I was telling the Chair that I've shed some blood myself in my life, but that was when I was much younger, Ms. Mossop. It was down at the Kingsley Hotel. It was called the Bucket of Blood. I was much, much younger. And I wasn't the only one shedding blood, I've got to tell you.

In any event, thank you very much. It's important stuff. That's why, Ms. Luski, if we can get a better handle on the data as to who is complying and who is not, I think that's interesting. Again, the assumption is that it's the people charged with crimes who are less likely to comply in general. There don't appear to have been any legal challenges in the data that has been presented to us by ministry people. Could we find out whether in fact—and how do people respond? Have people been represented by lawyers? Just to get a better sense of the experience in the 76 cases or so to date.

The Kingsley Hotel has quieted down significantly. They're all over 65 now. They can't fight anymore.

Mr. Bruce Miller: I'd just like to thank you for your support too, Mr. Kormos. I know we had your leader out to speak to our members last week, as we did Mr. Tory and Premier McGuinty, and all three leaders expressed their support. It's greatly appreciated.

Mr. Kormos: Thank you kindly.

The Chair: It's good to know you marked up the other guy as well.

Mr. Balkissoon.

Mr. Balkissoon: Mr. Miller and Natalie, thank you for taking the time to come here and for sharing your story with us. I want to thank your association for the work you've done.

Mr. Bruce Miller: I'd just like to take the opportunity to thank Natalie for all her work. These things aren't easy for people to walk in off the street and do, and we certainly appreciate everything she's done for our 30,000 members.

Mr. Balkissoon: We do too.

The Chair: As the Chair comes from Peel region, thank you very much, Natalie.

ONTARIO PROFESSIONAL FIRE FIGHTERS ASSOCIATION

The Chair: The Ontario Professional Fire Fighters Association, please. Take a seat anywhere. Make yourselves comfortable. You have 20 minutes to make your deputation this afternoon. If there's any time remaining, we'll divide it among the parties for questions. At your convenience, please introduce yourselves for Hansard and then proceed.

Mr. Brian George: Thank you, Chairman Delaney and members of the committee. My name is Brian George. I'm the executive vice-president of the Ontario Professional Fire Fighters Association, a 22-year veteran of the London fire department and a captain on the London fire department. With me today is Jeff Braun-Jackson, our office manager and the researcher for the OPFFA. Fred LeBlanc, president of the OPFFA, sends his regrets that he is unable to attend today. Thank you for this opportunity to address this committee.

The Ontario Professional Fire Fighters Association is a professional organization representing 10,000 full-time professional firefighters from across Ontario. The OPFFA serves our members' interests in numerous ways, from education to representation on matters concerning health and safety, workers' compensation benefits, pensions and legislation.

Our membership consists of firefighters who perform emergency response, prevention, public education, investigation, training, communications and maintenance. The priority of our members, as detailed in our code of ethics, is a commitment to the protection and preservation of life and property.

The OPFFA supports the objectives outlined in Bill 28, the Mandatory Blood Testing Act. As an organization

representing first responders, the OPFFA takes very seriously its responsibility to protect our members from being adversely affected by illness and disease. Our organization supported Bill 105 in 2001, and we continue to lobby for improvements to protect our members against illness and disease.

Our brief will provide examples from the front lines that will illustrate the need for Bill 28. As well, we outline a few recommendations that we feel would, if adopted, improve the bill to make it stronger and more effective.

Bill 28 seeks to replace section 22.1 of the Health Protection and Promotion Act, 2001. This section of the act specifies the procedures in which a police officer, firefighter, emergency services provider or good Samaritan could ask for someone to submit to a mandatory blood test in order to determine whether or not the first responder had been exposed to a blood-borne illness. The act did not come into force until 2003. However, it became apparent to stakeholders that the procedures spelled out in the legislation were cumbersome and inefficient, often making it extremely difficult for firefighters to determine in a timely manner whether or not they had been exposed to blood-borne pathogens.

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We have participated in stakeholder meetings that were held during 2005 and expressed our concerns at that time. Some of those concerns were as follows: Firefighters are increasingly called upon to provide a variety of emergency responses including, but not limited to, vehicle extrication, resuscitation and defibrillation. The provision of these services creates an additional risk for firefighters to come into contact with blood and bodily fluids from individuals requiring medical attention. Firefighters are required to act quickly to save the lives of fellow citizens, often without regard for their own safety. In a fire or medical emergency, firefighters often suffer cuts and scrapes because of the difficult, and at times restrictive, working conditions and environments.

Firefighters, unlike almost all other occupational groups, cannot refuse to carry out dangerous work as specified in part V, subsection 43(2) of the Occupational Health and Safety Act. Firefighters have no choice but to enter a burning building or use the jaws of life to remove an injured person from a mangled automobile. As such, firefighters must have the means necessary to make themselves aware of potential life-threatening illnesses that are contracted through the exchange of blood and bodily fluids. The right of a firefighter to know that he or she has been infected with an infectious disease such as HIV/AIDS or spinal meningitis outweighs the right to absolute privacy that an individual enjoys with respect to medical information.

The current time frame established in the act is too long. If a responder has been exposed to AIDS or HIV, he or she has approximately three hours to decide whether or not to take the drug cocktail as part of the post-exposure prophylaxis, commonly known as PEP. The drug cocktail contains numerous harmful side effects for that individual. Equally significant is the fact that a firefighter may not know whether he or she has been exposed to a blood-borne pathogen. The emotional and psychological anxiety caused by not knowing affects every facet of a firefighter's life: relationships with spouse, children, family and friends. Such needless anxiety and stress can be mitigated by reducing the long waiting period from application to decision in seeking to obtain the results from a blood test.

There were concerns as well about the process for securing information. For example, the medical officer of health had to transfer the application to the health unit of the respondent, the person from whom the blood test would be taken. If the individual was not from Ontario or was homeless and without a permanent address, needless delays would be the norm.

Unfortunately, as a front-line firefighter, I have had the experience of dealing with this myself. In the early part of this year, I was dispatched with my crew to a bicyclist struck by a truck on one of the busiest thoroughfares in London. The individual on the bike did not stop at a stop sign and rode directly into the path of the truck. The bicyclist suffered major head trauma, internal injuries and fractures, and was bleeding profusely. When we arrived on scene, a single officer was attending to the patient. My crew went to work to stabilize the patient immediately. When the paramedics arrived, it was decided to immobilize the patient as quickly as possible. The individual was violently thrashing around, due to his head trauma. While the firefighters and paramedics tried to restrain the patient, I went to assist them to hold down the legs while the paramedic tied him to the back board. The individual ended up kneeing me in the chest and knocking me forward, while unfortunately he coughed a mouthful of blood and saliva into my face. His bodily fluids had found a transmission point through my eyes at this point.

We have always used universal precautions in my department, but we had not been supplied with any protective eyewear for this type of incident. I immediately went to my truck in order to get the anti-viral hand cleaners that we used and used these to clean my face and even tried dispensing some of this into my eyes in order to disinfect them. As I was doing this, a woman who had witnessed what had happened came over to me to tell me that this man was a patient at the nearby methadone clinic where she worked, and that he was an chronic IV drug user and known to be a hepatitis C carrier and possibly HIV/AIDS-positive as well. You cannot imagine my sudden discomfort.

As soon as we finished assisting at the scene, we went directly to the emergency ward at the hospital to see what needed to be done. The paramedics had already alerted the physicians, because they had been exposed as well. I wanted to know what I needed to do as soon as possible. They indicated that a direct blood-to-blood transfer was the worst-case scenario and that my type of exposure was a lesser probability of contamination. If I was to start the post-exposure prophylaxis, I would need to start it within

a short while. The individual was not conscious, and they could not get consent for a blood test or even ask the questions. Blood tests were taken for other treatment reasons. The physicians told us that if I filled out the forms, it would take forever in the bureaucracy to get the answers and the results, and that would be longer than I would have to wait to start the PEP anyway. They wanted me to wait for a short while before I started my PEP treatments. I took the physician's advice and went back to our hall to package our gear for decontamination.

A short time after arriving back at our hall, I received a phone call from someone who would not identify themselves; however, they knew enough details to make the phone call legitimate. The individual was not HIV-positive but had tested positive for hepatitis C. The individual has never regained consciousness to this date and has no known relatives. No person would have been able to give consent for that blood test.

There is no treatment for this hepatitis C. I have been going through monthly testing since the incident, since the exposure, and I will continue to do so for up to two years. Fortunately, to date I have received a clean bill of health each time, thankfully. The emotional stress this has put on myself, my spouse and my family is immense. I am told the likelihood of contracting this disease from this type of transmission is very low. While that is reassuring to hear, it still does not alleviate the unknown. This law would have eliminated the need for that late-night phone call.

The OPFFA acknowledges that requiring someone to submit to a blood test is not desirable. However, the constitutional protections afforded to Canadians under the Charter of Rights and Freedoms are not absolute but rather are subject to reasonable limits. We believe that when a firefighter, police officer or emergency responder has reasonable and probable grounds to believe that he or she has been exposed to a blood-borne pathogen, it is crucial that the blood and/or bodily fluids of that source person be tested immediately. We recognize that privacy and confidentiality must be vigilantly protected in our society, and safeguards can be put in place to secure the information provided as a result of a mandatory blood test. The risk of infection, the needless emotional and psychological anxiety caused by not knowing whether or not you are infected and the likelihood of having to endure a PEP to limit the consequences of any exposure are reasonable limits on an individual's right to privacy.

Our position is as follows: We support Bill 28 because the legislation recognizes the need for first responders to be protected from exposure to blood-borne pathogens and diseases as a result of their working conditions. While the government has taken great strides to improve the current system through legislation, there are some areas of the bill that the OPFFA feels can be strengthened to make it better, more comprehensive and more effective in protecting firefighters, police officers, emergency workers, victims of crime and good Samaritans.

We make the following recommendations:

We support reducing the amount of time that a firefighter must wait before a decision to require a blood test is made. We also support transferring responsibility for the decision from the local medical officer of health to the Consent and Capacity Board. It is our understanding that the Consent and Capacity Board can meet as one person. Given that the nature of our work requires a response 24 hours a day, seven days a week, it is highly conceivable that an exposure could occur during nights, weekends or holidays, when others may not be readily available to address an exposure request. Therefore, should a firefighter be exposed to blood or bodily fluids while performing his or her work and that individual believes that the person whose blood and/or bodily fluids came into contact with them may be infectious, he or she should be able to have a member of the board issue a request for the source individual to submit to a blood test if that individual's medical records cannot be accessed or made available. The burden of proof is on the applicant to show just cause in requiring the blood test from the source person as it is in the bill.

In conjunction with streamlining the process for requesting a decision, we suggest that the minister consider that the Office of the Information and Privacy Commissioner be involved in the process. A representative from the Office of the Information and Privacy Commissioner could act as a safeguard to ensure that the privacy of the source person be protected should he or she be required to submit to a mandatory blood test. The inclusion of a representative from this office would not only make the process transparent but would allay the fears of those who believe that the source person's blood sample results may be used in ways that are harmful and injurious.

We would support the inclusion of spinal meningitis in the prescribed list of communicable diseases.

We would advocate that the privacy concerns of firefighters and other first responders, with respect to names and addresses, be acknowledged in the same manner as the person whose blood is being tested.

Firefighters do suffer emotional and psychological stress as a result of not knowing whether or not they have been infected, as well as physical side effects from medications taken to deal with exposure to an infectious disease. We believe that these areas should be eligible for workers' compensation, similar to other workplace injuries and any other programs made available.

In keeping with the concept of dealing with and/or mitigating exposures to infectious disease, if possible, enact a regulation that mandates the use of safety-engineered sharps devices to protect first responders and health care workers from being injured by needles.

In conclusion, the OPFFA strongly supports Bill 28. Our members require protection from infectious diseases caused by blood-borne pathogens. We respect the right of privacy of all Canadians enjoyed under the Charter of Rights and Freedoms but believe that the right is not absolute and needs to be balanced in specific circumstances.

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Firefighters and other first responders must have the ability to determine quickly and efficiently whether or

not they have been infected by contact with another person's blood and bodily fluids. Bill 28 will ensure that this is a reality, and we thank the government, specifically Minister Kwinter, for introducing this legislation.

The Chair: Thank you. We have time for a brief question from each caucus, beginning with Mr. Kormos.

Mr. Kormos: Thank you very much. No quarrel. However, I've got to raise this. If you look at the flowchart that the ministry provided, it's a little confusing for me. There's a suggestion that after the medical officer of health reviews the application, he or she can do one of two things: to proceed to seek the voluntary compliance or dismiss the application. I don't understand that because, in the bill itself, there doesn't seem to be any discretion on the part of the medical officer of health. If an applicant falls into one of those categories, then the medical officer of health is compelled—he or she doesn't weigh the risk—it's the CCB, under the bill, that will determine whether it's arguable that the exposure was of such a type that it doesn't warrant a blood test.

I'm using my brief time with you to raise that—if we can get that answered and resolved before we're finished here. It's just confusing to say the MOH can dismiss the application when there's no discretion whatsoever in the bill. And I'm not suggesting that there should be, because that discretion will be exercised at basically the review level of the CCB should somebody not voluntarily provide.

Otherwise, thank you for your comments.

The Chair: Do you have a response on that?

Mr. Kormos: No, I don't expect these folks to. I'm raising that—

Interjection.

Mr. Kormos: I was looking over their shoulder, yes.

The Chair: All right. As it's now the turn of the parliamentary assistant, did you have any response to Mr. Kormos? In any event, it's your time.

Mr. Kormos: We'll leave it to the staff.

Mr. Balkissoon: We'll leave it up to the ministry staff, as we get to clause-by-clause, to come back and provide clarification, Mr. Chair.

I just wanted to say to the deputants, thank you very much for being here and giving us your input and your comments on the IPC and spinal meningitis. I will ensure that the minister is aware of your request.

Mr. George: Thank you.

The Chair: Mr. Dunlop or Mr. Miller?

Mr. Dunlop: Very, very similar comments. If it's possible to make some of these minor amendments, we certainly would consider that next week. We'll see what happens, some of the advice of the ministry staff etc. But again, thank you for being here. I wasn't aware, Brian, that you'd gone through that this summer. I'm sure there's a little bit of pressure on yourself as well.

Mr. George: Unfortunately, I'm not the only one in our department. This is a quite regular incident. It doesn't happen to every single firefighter or police officer, but it does happen on a more-than-often regular basis now, and that's why we're here supporting the bill and why we supported yours back in 2001 as well.

Mr. Dunlop: In the consultations we did even in 2001, we were getting guys, firemen, who were getting the crack houses with needles hidden all over the place, below the vanities and this sort of thing, the kitchen sink, you name it. There were incredible stories they came out to tell. It's too bad that more people couldn't hear some of those stories to understand why we really do need this kind of legislation, and the quick response as well.

Mr. George: Thanks, Mr. Dunlop.

The Chair: Mr. Miller, did you have a question?

Mr. Norm Miller: Certainly. In your presentation, you said that you need to know within three hours in the case of, I think it was, AIDS. It could be 19 days or longer if you get an unco-operative respondent, so how do you address the three-hour situation?

Mr. George: Three hours is the time period in which you need to take the post-exposure prophylaxis, so if something can be done so you can get that. Hopefully, you have an individual on the other side who's willing to say yes or no and give you that information. However, unfortunately, in my case, the individual is still not able to, and I know that in Officer Hiltz's case, that individual is not willing to. There needs to be something in there that gives these members that ability to quicken up that time frame.

Mr. Norm Miller: So are you going to make the suggestion in terms of your situation, where the individual you were dealing with, as you said, is still not conscious?

Mr. George: No.

The Chair: Before I moved away from the government side, I missed Mr. McMeekin's body language. The government side still had a little bit of time remaining, so my apologies. Mr. McMeekin has a question.

Mr. McMeekin: Thanks very much. I just so appreciate your coming out and sharing, and Mr. Miller and his colleague are as well.

I'm of the opinion, frankly, that the benefit of the doubt ought to go to those folks who put themselves in harm's way. I'm wondering about the science here. I know Mr. Miller made some passing comment about charter concerns and legal issues, and I'm assuming that we've had some discussion about that. But I'm wondering if, either through a staff person here or the clerk, we can have whatever information has been gathered about the timeline around the science, because, frankly, I'd be prepared to be even tougher if that's what it takes to protect the front-line folks. So I ask a generic question about the science and about the law.

Surely to goodness, there have to be ways. You bite somebody: You give up some of your rights right there. If you're in that class, if there's some clear evidence of that, I'd make it—poof, right on the spot, if there was clear evidence of that.

I just raise that question. I don't know who can answer it, but I want to get it on the record.

The Chair: Any further comment?

Mr. George: I'm not able to answer that.

The Chair: Okay. That's not surprising. Thank you very much for having come in today.

ONTARIO ASSOCIATION OF FIRE CHIEFS

The Chair: The Ontario Association of Fire Chiefs, please. I'd like to welcome you both this afternoon. You have 20 minutes for your deputation, and if you leave any time remaining, I'll divide it among the parties for questions to you. Please begin by introducing yourselves for the purposes of Hansard and then proceed.

Ms. Cynthia Ross-Tustin: Thank you, Mr. Chair. My name is Cynthia Ross-Tustin. I'm the deputy fire chief for the town of Bradford-West Gwillimbury. I'm here with my colleague Mr. Ghislain Pigeon from the Hawkesbury fire department; he's their chief. We're here representing the Ontario Association of Fire Chiefs.

It's my pleasure to be here before you today and speak for our members. We have approximately 487 members within our association, but we represent over 29,000 firefighters. That's both full-time and volunteer. We are the leaders of the fire service, and we feel very strongly in support of this bill. We would just like to maybe speak to some improvements to it.

I would also add perhaps for Mr. McMeekin, I'm an ICU trauma unit nurse by trade, and I have dealt with this issue, unfortunately, on both sides of the fence. I look after my staff and their health issues and their concerns when we deal regularly with violent patients, violent people on the scene or a traumatic scene from an auto extrication, but I've also been in the emergency room when we have people whom we know or have serious reason to believe are HIV-positive, and we cannot share that information, and these people need it. These are the people on the front line, these are the people protecting the people in your municipalities, and they're the people who don't have a choice.

So briefly, we would like to thank everybody for the support of this bill. I think we're all in agreement. I hear my colleagues saying the same thing. We were all at the table in support of Bill 105. We found it very cumbersome. We dealt with the stakeholders' groups after the fact, with Dr. Sheela Basrur, when the stakeholders were convened, and we very much appreciated the opportunity for input at that time.

The primary thing that came out of all that stakeholder input was that the process is cumbersome and it takes too long for those who put themselves at risk to get an answer whether or not they need to take the PEP—here we go—the post-exposure prophylaxis. And it gets even worse when you start to look at the antiretrovirals that are necessary for this process.

Again, we are in support of Bill 28 because it makes substantial improvements to what has happened in the past, and I believe they've taken the stakeholders' groups into consideration when it comes to these improvements. But from a medical point of view, having worked with this, 24 to 48 hours is when you need to find out before one of us will go through what's called seroconversion and our T3s and our C4 cells are different. That's not a lot of time before we go ahead and have to take the "toxic cocktail," as it's referred to.

We call it that because it's not just one drug, an AZT or a multitude of other things; it's several drugs. It's as toxic and as harmful to you as chemotherapy, and I don't know that anybody in this room would willingly hop on the bus and take chemotherapy. You've heard about some of the side effects, but those are some of the easier side effects: the exhaustion, the nausea, the vomiting, the diarrhea. But a lot of people don't tell you, when you're having to decide whether or not you want to take this toxic cocktail, that it affects your lipid and your fat levels; it can either elevate them or lower them to the point where you can have cholesterol issues. It can also cause the fat to store in your body; it can completely change your appearance with the fat deposits on your face.

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There are a lot of issues. Some of the simple facts are that people are too exhausted, too sick to go to work. People who were otherwise active, vital, healthy people who were out there responding to emergencies are now sick at home simply because they've had to take medication that they really had no choice about, no other option. That affects our fire and emergency services. If those workers are sick at home, they're not at work. These are highly trained, effective people and they're at home sick, not able to do what they do best. That affects the municipality. That affects our workload.

The other side of the coin that you need to look at is that a lot of these people—19,000 firefighters in this province—are volunteer firefighters. Who's looking after their interests when they have to wait? A lot of these people don't have protection or long-term health benefits. Some of these people have to take the cocktail, they're sick at home, and they have no money; there is no money coming in to support them. Who looks after them? That's a heck of a risk to ask somebody to take for free, to volunteer to do. It's going to affect a lot of issues. Would you volunteer to put yourself at that kind of risk? It's going to be more difficult.

These are some of the issues we face as the leaders in the fire service. What do we do when our people are affected or infected, as the case may be? It causes a great impact on our service and it causes immeasurable impact on the lives of emergency service workers, people who had no choice other than to go and respond.

We respect the rights of those to their privacy and we support the amendment to make sure that their names stay private. We also support the concept that the firefighters' names need to remain private. But I believe that the needs of the many perhaps may outweigh the needs of the few. We can't continually ask people to put themselves in harm's way and then be in harm's way after the fact; it's an awful lot to ask.

In summation, I'll reiterate what all of my colleagues have said. We appreciate Mr. Kwinter's bill. We appreciate the support for emergency workers. We think this is an excellent bill. We would just really like it if you would tweak the timeline and make it a little more

effective and a little more immediate. The compelling of a sample is quicker, easier, faster and—I hate to say it—cheaper than the thousands and thousands of dollars it would take to—the last quote I heard when I was still practising nursing is that the HAART, the highly active antiretroviral therapy, starts at about $19,200 by the time you take into consideration all the blood work, the care, the process and the follow-up required, as opposed to a simple blood test. It's also easier in northern Ontario to get a blood test than it is to get your hands on antiretroviral.

Thank you for your support. If you have any questions, Mr. Chair, we appreciate your time.

The Chair: Thank you very much. Mr. Balkissoon?

Mr. Balkissoon: I just want to thank you very much for taking the time to come here and be with us to share your thoughts. Let's hope we'll have some experience over the next coming years that if we can do anything, we will.

Ms. Ross-Tustin: Thank you, sir.

Mr. Norm Miller: Thank you very much for your presentation. Do you have any specific suggestions for amendments to speed up the timelines?

Ms. Ross-Tustin: We believe that the 24 to 48 hours is the most appropriate in which to compel a blood sample. That's where we need to make the assessment to change—anything after that, if we don't have an answer, we have to take the cocktail. Nobody is willing to risk or take the gamble. You have to give us an answer, positive or negative, within that time frame so that our staff, your people, can make those kinds of decisions. Otherwise, it's rather a moot point.

The Chair: Mr. Kormos?

Mr. Kormos: Thank you very much. An interesting and very bold submission. I appreciate the candour, because you're quite right: At the end of the day, a seven-day or nine-day time frame will simply give the victim of the infection the comfort of knowing that he or she isn't infected. Is it fair to say that there are some—can HIV necessarily be detected within seven to nine days? Might it sometimes take longer?

Ms. Ross-Tustin: There is a small portion. If somebody has been recently infected with HIV, they may not have seroconverted.

Mr. Kormos: So you still have the problem of the bleeder having HIV. The victim—the firefighter or paramedic—knowing that the bleeder has HIV, has a high anxiety level. Obviously, the world just gets turned upside down for him or her and their family. Then they get tested and they're told, "You don't have HIV, but you still might." But here's the dilemma: Three hours was the optimum time for the PEP dosage, and then 24 to 48 hours I presume is the outside time. What do you do in a community, especially—you're right—like northern Ontario? The medical officer of health is on vacation with his or her spouse and kids. The medical officer of health is testifying at some committee hearing in Toronto. Seriously, these are real problems. And also—and this is where we have to get some help, folks, from the ministry with the data, because Ms. Drent, in her research paper, says that in most cases applications are dismissed, which is where she talks about the very few orders that are issued. What are you suggesting?

I wondered in the first round—Garfield might remember—why a justice of the peace wasn't involved. Because they're usually available 24-7, they're more readily available. A JP can weigh the law. You've got the medical evidence, the prima facie evidence of the doctor. At that level, it's not rocket science, because all you'd have to know is that there's blood and contact, right? So it ain't rocket science at that point. JPs are more readily accessible, and you have judicial oversight, then, of this intrusive entry into somebody else's body, which is a factor in the Charter of Rights and so on. So I'm wondering, Chair—and ministry staff will have a chance to talk about this in clause-by-clause—how do we address these particular concerns? Why isn't a JP, notwithstanding the chronic shortage—that was a partisan comment—

Mr. McMeekin: I got it.

Mr. Kormos: You picked it up, did you, Ted?

Mr. McMeekin: I'm pretty sharp.

Mr. Kormos: Why isn't a JP being utilized as the gatekeeper here, if you will, as the controller? That way you really could have a one-hour or two-hour turnaround. Because a person either voluntarily—a paramedic taking people in on a stretcher, or a firefighter: "Will you give blood?" "Yes, I'll give blood for testing." No? Boom. Get an application form in front of a justice of the peace, who is usually, or ideally should be, available 24-7. I don't know. We should get answers to that.

The Chair: Thank you. The repartee and the questions to the ministry notwithstanding, did you wish to make any comment on that?

Ms. Ross-Tustin: I'm not sure I can answer all of Mr. Kormos's legal questions, Mr. Chair, but I noted that Mr. McMeekin pointed out suspicion as well as probable cause. In 1995, emergency service people from across Canada got together. We've done, I believe, the best job we possibly can in putting all the pre-screening things in there. We've done all we can do to protect our workers. We have developed guidelines; we have put in place all the recommendations from the medical field for personal protective equipment; we encourage our staff to have their vaccines. Obviously, there is a vaccination for hep B; we're hoping for hep C. Toronto has done some of the best research in the world on AIDS, so perhaps the first vaccine will come from here. We have put protocols in place to work with health care people and the screening process, so when somebody goes perhaps before a JP or somebody else, they have more than just a little bit of reason to believe that this person is infected with HIV. The homework has been done, the screening process has been in place, and a doctor is recommending with very solid background that this person has been exposed and there's probable cause for this person to be compelled to have their blood tested.

That would be my remaining point. I thank you all for your time.

The Chair: Thank you very much for having come in today.

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ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES

The Chair: Our final deputation is from the Association of Local Public Health Agencies.

Mr. Kormos?

Mr. Kormos: Chair, through to Ms. Luski from legislative research: JPs sign search warrants all the time, including body searches and cavity searches. There have even been search warrants that involve items, as I recall it, under the skin or ingested. Could we get legislative research to just give us a brief overview of the extent to which JPs grant search warrants? How intrusive? Can they sign a search warrant that permits, let's say, a search for something that might be contained in the intestines—presumably the lower intestines, hopefully, for the sake of the person being searched—in the context of pulling blood for the purpose of this legislation?

The Chair: Thank you. So noted.

Good afternoon and welcome. You'll have 20 minutes for your deputation. If you leave any part of that time remaining, it'll be divided among the parties for questions. Please begin by introducing yourself for Hansard and then proceed.

Dr. Rita Shahin: Thank you. Mr. Chairman, members of the committee, good afternoon. My name is Dr. Rita Shahin and I am here representing the Association of Local Public Health Agencies, or alPHa. alPHa represents the interests of boards of health, medical officers of health and affiliate groups who work in the field of public health. I am pleased to be here this afternoon to address you on the very important issue of mandatory blood testing.

I would like to acknowledge the very real anxiety and concerns of those covered under this bill, particularly first responders who may, during the course of their duties, be exposed to the blood or body fluid of others. As a physician, I know first-hand how difficult and stressful this can be. I am thankful for their hard work and commitment to public safety.

Before addressing Bill 28 specifically, I feel it is important to clearly understand the degree of risk posed by these types of exposures. The risk of transmission of blood-borne pathogens in these types of situations is extremely low. In fact, to my knowledge, there has never been a case of occupational transmission of blood-borne pathogens in police, firefighters, ambulance attendants or correctional staff in Canada. Those who face the highest risk of transmission are laboratory workers and health care workers, particularly operating room nurses and surgeons.

The main diseases of concern from exposure to blood or body fluids are hepatitis B, hepatitis C and human immunodeficiency virus, or HIV. Of the three diseases, hepatitis B is the one that is most likely to be transmitted, with 6% to 30% of people becoming infected following a significant exposure such as a needlestick injury. However, hepatitis B infection is also preventable by means of a safe and effective vaccine. Universal hepatitis B immunization is offered to all grade 7 students in Ontario, and occupational immunization programs are available to ensure that first responders and health care workers are adequately protected.

The risk of transmission for hepatitis C falls between that of hepatitis B and HIV: 1.8% of people will become infected with hepatitis C following a needlestick injury from an infected source. There is no vaccine to prevent infection prior to exposure and no drugs currently available to prevent infection following exposure.

The risk of infection with HIV is much lower than that seen for either hepatitis B or hepatitis C. Following a needlestick injury from an infected source, 0.3%, or three of every 1,000 people, will become infected with HIV. The risk is even lower, 0.1%, for blood splashes onto mucous membranes—those include the eyes and inside of the nose or mouth—or onto broken skin. Antiretroviral drugs, also known as post-exposure prophylaxis, or PEP, are available to prevent infection following the exposure. These drugs must be started within one to 72 hours after the exposure, and ideally between one to four hours to be the most effective, and are taken for a four-week period. The drugs have serious side effects in up to 50% of people taking them, and it's estimated that one third of people usually discontinue the medications before the four-week period is over.

Mandatory testing cannot be used to influence the decision to start HIV post-exposure medications as it cannot occur quickly enough to inform the decision-making process. It may be helpful in making a decision to stop these medications before the end of the four-week period. However, even a negative HIV test result may not be accurate if the source person is in the early stages of HIV infection, and the early stages is the period when that person is most infectious to others. The legislation does not include obtaining clinical or risk-factor information on the source person; therefore, the drugs may be stopped on the basis of a negative test result when in fact they should be continued based on the risk factors of the source person.

The best way to prevent these infections is through comprehensive pre-exposure programs that provide pre-exposure immunization for hepatitis B, education on the use of personal protective equipment, access to adequate supplies of personal protective equipment, and protocols for prompt assessment, counselling and follow-up of exposures, including immediate access to antiretroviral treatment for HIV at no cost, should this be necessary. Access to post-exposure prophylaxis across Ontario right now is quite inconsistent, especially in smaller urban or rural centres.

Pre-exposure programs are currently in place to protect first responders and health care workers. These programs must continue to be adequately staffed and resourced and keep up to date with advancements in knowledge related to blood-borne pathogens. Again, it is important to note that we have never had a occupation-

ally-related documented transmission to first responders in Ontario or Canada.

Bill 28 seeks to replace the current section 22.1 of the Health Protection and Promotion Act. Section 22.1 has been in force since September 2003 in Ontario. In the first two years that section 22.1 has been in existence, 58 applications for the taking of blood samples were brought forward to medical officers of health in Ontario. Just over half of these applications, or 31 to be exact, were successfully resolved using the voluntary process. One order was issued, and the rest of the applications were either dismissed or refused for not meeting the current requirements. To the best of my knowledge, the order that was issued was not complied with. Taking a blood sample from someone who has not consented to the procedure creates serious logistical issues for the health care provider who must draw the blood. Is the blood to be drawn by physically or chemically restraining the respondent, and how can we ensure the safety of the health care provider who must draw the blood?

Mandatory blood testing appears to address mainly the issues of side effects of antiretroviral therapy and the anxiety of not knowing whether the respondent is infected with a disease. This seems to be an extremely broad interpretation of the risk to health that must be present in order for an order to be issued. Given this low risk to health and the difficulties inherent in trying to obtain a blood sample from someone without their consent, I do not feel that there is sufficient evidence to warrant mandatory blood testing in Ontario.

Bill 28 has three significant changes from the current section 22.1 of the Health Protection and Promotion Act. The first of these is to shorten the timelines for the voluntary process by five days, bringing it down to two days from seven. The second is to refer the application for decision-making to the Consent and Capacity Board instead of the local medical officer of health. Finally, Bill 28 removes the right of appeal for both the applicant and the respondent. I would like to address each of these three changes.

Shortening the voluntary process will result in both potential benefits and harms to applicants. This change will decrease the number of applications that the medical officer of health can successfully resolve voluntarily, as it can often take a couple of days to locate the respondent, particularly if they are in a correctional facility. This will result in more applications moving to the mandatory stage of the process, lengthening the overall time it will take to resolve the situation. Reducing the voluntary period will reduce the overall time to reach a decision by five days; however, the entire process may still take up to three weeks to resolve, taking into consideration the many steps along the way. This still does not address the issues related to HIV post-exposure medications, as applicants would be finished most of the course of the medications before a test result is received.

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I would like to now address the second change in Bill 28, which shifts the responsibility for applications from medical officers of health to the Consent and Capacity Board. Medical officers of health have had serious concerns with their current role under section 22.1 of the HPPA, as this has moved us out of our role as an advocate for the public's health into a quasi-judicial role, ruling on the competing interests of two individuals. However, the changes in the bill do not go far enough to address our concerns. Our role or involvement in the process should stop after the voluntary process has ended. The bill, as it is currently drafted, requires the Consent and Capacity Board to order the medical officer of health to provide a lab requisition form in order for the respondent to be tested, should the board rule in favour of the applicant. The Consent and Capacity Board should order the respondent directly, without involving the medical officer of health in the process. We would suggest that the Consent and Capacity Board hire a physician who can provide them with the medical advice needed to consider these applications and who can also provide the laboratory requisition, should an order be issued. Another alternative would be to issue the order to the respondent's health care provider, who can then provide the lab requisition. Involving us in the order process jeopardizes our role in working with both exposed and infected individuals.

Subsection 9(5) of the bill states that, "Nothing in this act creates a physician-patient relationship or other relationship of trust between a medical officer of health and an applicant or respondent." In the event that a respondent is found to be infected with a blood-borne pathogen, I believe there's still an ethical obligation on the part of the medical officer of health, if they are the testing physician named, to ensure that the individual receives appropriate care. Again, this goes against the role of the medical officer of health, who is not usually in the business of providing clinical care to individuals.

Finally, I would like to express my concerns about the removal of the appeal process for either the applicant, the respondent or the medical officer of health, who may be in disagreement with the board's decision. I would argue that a much more significant risk to health should be present before the rights of the source person to consent to blood testing are abrogated without right of appeal.

In conclusion, if mandatory blood testing must continue to exist in Ontario, this bill should be amended to restrict the role of the medical officer of health to the voluntary process.

Mr. Chairman, members of the committee, I would like to express my gratitude for the opportunity to address these issues.

The Chair: Thank you very much. We should have time for a question from each caucus, beginning with Mr. Miller.

Mr. Norm Miller: Thank you for your presentation. Just in terms of the time factors involved, I have a question to do with an HIV test. If the bleeding person does voluntarily comply to a test, what sort of time frame is involved in terms of knowing the results of that test?

Dr. Shahin: Currently, if somebody voluntarily consents, the central public health laboratory will perform

those tests on an expedited basis, and we can have those results back usually within 24 hours. There is a new rapid test for HIV that's available that can provide tests within 10 or 15 minutes. However, that test is not provided to health care providers in Ontario at this time.

Mr. Norm Miller: So there is actually a test that's 10 or 15 minutes, because time seems to be the big concern—

Dr. Shahin: That's right.

Mr. Norm Miller: —if you're the person who may be infected by contact with someone who has HIV, in terms of making that big decision to take a month's worth of toxic drugs or not.

My second question—

The Chair: And it should be a very short one.

Mr. Norm Miller: My very short second question has to do with the cost factor. You say that the access to antiretroviral treatment should be at no cost. Is there a cost? We had one person earlier say that they had to pay out of their pocket. I was kind of surprised by that, to be honest.

Dr. Shahin: The cost runs into $1,000 or $2,000, depending on which drugs are prescribed. Most workplaces may cover that cost. However, for a good Samaritan—

Mr. Norm Miller: So it's not covered by OHIP?

Dr. Shahin: No, it is not. So a good Samaritan who's exposed would have to pay out of pocket unless they had private insurance.

The Chair: Mr. Kormos.

Mr. Kormos: Thank you very much—very interesting insights. But let's be fair: Over the course of two and a half years, there haven't been a whole lot of applications made; a total of, depending upon whose data you look at, 61, 70. I'm confident that there have been a whole lot of paramedics, firefighters, police officers and others up to their elbows in blood in any number of circumstances. Clearly, the application process, in my view, hasn't been abused. People have been very discreet about making these applications. That's number one.

Number two, I agree with you about the time frames. Either you've contracted the disease or you haven't. Short of voluntary and sort of the perfect storm situation, the practicality of getting the blood tested within the first half-hour or so is very, very minimal. Primarily, this is about providing, in my view, a level of psychological and emotional comfort for the victim of the bleeding, especially when, as you point out, early HIV testing of the victim, even though they have been infected, may not reveal HIV. Knowing that the bleeder doesn't have HIV is going to put that person a lot more at ease.

But the other interesting thing—take a look at clause 5(2)(a). CCB makes an order. It can, in clause (b), require the respondent to allow a physician named—in other words, it can make a direct order, but in clause (a) it makes an order "requiring the medical officer of health...."

The Chair: You may want to wrap up your question if you want to get a fulsome answer.

Mr. Kormos: Yes. Question: Why would we want to put the medical officer of health in a position where he, for instance, might advertently or inadvertently violate an order? Don't they do enough? When you've got clause (b) that allows the CCB to directly require the respondent to give blood—is that the point you were making?

Dr. Shahin: Yes, that is the point. I feel that the medical officer of health should not be involved in that order process.

Mr. Kormos: Because he or she is removed from the process; they've done their job initially and you've moved on to the CCB. You let the CCB make its orders. That's what you're saying, huh?

Dr. Shahin: That's right.

Mr. Kormos: It makes good sense to me.

The Chair: Thank you. Dr. Qaadri.

Mr. Shafiq Qaadri (Etobicoke North): Dr. Shahin, I, of course, appreciate the different risk levels depending upon the exposure type. I'm sure you're aware that it was as a result of a couple of surgeons at the University of Toronto contracting hepatitis B that hepatitis B prophylaxis became general throughout Ontario. So I was surprised to hear that a physician would not support mandatory testing.

The other thing that seemed biologically counterintuitive was this idea that the bleeder, a potentially HIV positive patient but not HIV positive yet, would be more infectious in the initial stages. Why would that be?

Dr. Shahin: In the early stages of the infection of HIV—in the first couple of weeks—people have a very high viral load in their blood and therefore are much more infectious to others. At that point in time, they wouldn't have antibodies showing that they're HIV-infected.

Mr. Qaadri: All right. To Ms. Mossop.

Ms. Mossop: Just to clarify, you mentioned that there is a test that you can get the results of in 10 or 15 minutes, but it is not available to health care providers. Yet if we shift over to a health care provider doing the order, then we may have to address that issue as well.

Dr. Shahin: It's a test that's currently licensed in Canada. However, it is not available through the current laboratory system at no charge. I think physicians could access it but would have to pay for it, or the clients would have to pay for it themselves.

Ms. Mossop: So we'd have to make sure, if there's any change, that that's addressed as well.

The Chair: Mr. Balkissoon.

Mr. Balkissoon: I just want to say, thank you very much for taking the time to come out and share your thoughts with us. Definitely we will follow up on your last comment.

The Chair: Thank you very much. Thank you to all the deputants for having made the time to come in today and enlighten the committee. This meeting is adjourned.

The committee adjourned at 1658.

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